Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOWNTOWN PLAZA IMAGING
201 CRAWFORD SUITE 111A
HOUSTON TEXAS 77002

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
PPG INDUSTRIES INC

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-1490-01

MFDR Date Received
October 20, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a cervical ESI (Epidural Steroid Injections) 1st and 2nd in a series of 3. We have never received a denial from carrier. It was mailed 2x."

Amount in Dispute: $1,673.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the DWC060 request.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2003 and December 4, 2003	Radiology Services, Supplies, Electrocardiogram, Prolonged Office Visit, Injections, Anesthesia	$1,673.31	$1,232.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute filed on or after January 1, 2002.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
4. The requestor did not include copies of Explanation of Benefits with the DWC060 request. The insurance carrier did not respond to the DWC060 request. Therefore no EOB's were made available for this review. The requestor, however, submitted sufficient documentation to support that an initial and reconsideration bills were sent to the insurance carrier for audit review.

Issues

1. Did the requestor bill according to the provisions of 28 Texas Administrative Code §134.202?
2. Did the requestor submit documentation to support fair and reasonable reimbursement per division rule at 28 TAC §134.1?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for date of service November 13, 2003. Review of the CCI edits finds:
   - Date of service, November 13, 2003: Procedure 99354 is an Add-On code and must never be billed without primary code(s) 90809-90809-90815-90815-99201-99215-99241-99245-99324-99337-99341-99350. The requestor did not bill a primary procedure code, therefore, reimbursement is not recommended for CPT code 99354.
   - Date of Service, December 4, 2003: Procedure 99354 is an Add-On code and must never be billed without primary code(s) 90809-90809-90815-90815-99201-99215-99241-99245-99324-99337-99341-99350. The requestor did not bill a primary procedure code, therefore, reimbursement is not recommended for CPT code 99354.
   - Date of service, November 13, 2003: CCI Edit - Procedure 62281 and component procedure 93005 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement is not recommended for CPT code 93005.
   - Date of service, December 4, 2003: CCI Edit - Procedure 62281 and component procedure 93005 are unbundled. The Standard Policy Statement reads "Standards of medical / surgical practice". Reimbursement is not recommended for CPT code 93005.
   - Date of service, November 13, 2003: Medicare considers Procedure Code 94760 as a bundled service when other payable services 62281 are billed on the same day by the same provider and department. Reimbursement is not recommended for procedure code 94760.
   - Date of service, December 4, 2003: Medicare considers Procedure Code 94760 as a bundled service when other payable services 62281 are billed on the same day by the same provider and department. Reimbursement is not recommended for procedure code 94760.
   - Date of service December 4, 2003: Procedure 99070 x 2. Payment for this service is always bundled into payment for other services not specified and no separate payment is made. Reimbursement is not recommended for procedure code 99070 x 2.
2. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."
   - Review of the DMEPOS fee schedule (cgsmedicare.com) did not contain a fee schedule amount for HCPC codes J2765, J1200, J0702, J3490, J3010, J2000, J3360, A4645, and J7040.
   - Review of the Texas Medicaid Fee Schedule did not contain a fee schedule amount for HCPC codes J2765, J1200, J0702, J3490, J3010, J2000, J3360, A4645, and J7040.
   - HCPC codes J2765, J1200, J0702, J3490, J3010, J2000, J3360, A4645, and J7040 are therefore subject to the provisions of 28 Texas Administrative Code §134.1.

   Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- Date of service, November 13, 2003: The requestor billed HCPC codes J2765, J1200, J0702, J3490, J3010, J2000, J3360, A4645, and J7040.
- Date of service, December 4, 2003: The requestor billed HCPC codes J2000, J3360, J7040, J2765, J3010, J0702, A4645 and J3490.
- The HCPC codes indicated above do not have a Medicare or Texas Medicaid assigned values.
- Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
- Date of service, November 13, 2003: The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for HCPC codes J2765, J1200, J0702, J3490, J3010, J2000, J3360, A4645, and J7040.
- Date of service, December 4, 2003: The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for HCPC codes J2765, J0702, J3490, J3010, J2000, J3360, A4645 and J7040.
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

3. The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Payment cannot be recommended for or HCPC codes J2765, J1200, J0702, J3490, J3010, J2000, J3360, A4645, and J7040 rendered on November 13, 2003, and HCPC codes J2000, J3360, J7040, J2765, J3010, J0702, A4645 and J3490 rendered on December 4, 2003.
4. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used." The requestor submitted documentation to support the billing of the services noted below. Review of the submitted documentation finds that:
    - Date of service: November 13, 2003, the requestor billed CPT code 62281-WP, defined as Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid. The requestor appended modifier -WP to identify that the requestor provided the technical and professional component of the injection. The Medicare fee schedule amount is $501.31. This amount is recommended.
    - Date of service: December 4, 2003, the requestor billed CPT code 62281-WP, defined as Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid. The requestor appended modifier -WP to identify that the requestor provided the technical and professional component of the injection. The Medicare fee schedule amount is $501.31. This amount is recommended.
    - Date of service, November 13, 2003: The requestor billed CPT code 71010-WP, defined as Radiologic examination, chest; single view, frontal. Modifier –WP identifies that the requestor provided the technical and professional component. The Medicare fee schedule amount is $34.82. This amount is recommended.

- Date of service, November 13, 2003: The requestor billed CPT code 72050-WP, defined as Radiologic examination, spine, cervical; 4 or 5 views. Modifier –WP identifies that the requestor provided the technical and professional component. The Medicare fee schedule amount is $65.14. This amount is recommended.
- Date of service, November 13, 2003: The requestor billed CPT code 72240-26, defined as Myelography, cervical, radiological supervision and interpretation. Modifier -26 identifies that the requestor provided the professional component. The Medicare fee schedule amount is $59.02. This amount is recommended.
- Date of service, November 13, 2003: The requestor billed CPT code 76003-26, defined as Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device). Modifier -26 identifies that the requestor provided the professional component. The Medicare fee schedule amount is $35.50. This amount is recommended.
- Date of service, December 4, 2003: The requestor billed CPT code 76003-26, defined as Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device). Modifier -26 identifies that the requestor provided the professional component. The Medicare fee schedule amount is $35.50. This amount is recommended.
- Date of service, November 13, 2005, the requestor billed CPT code 01905, defined as Anesthesia for myelography, discography, vertebroplasty. Per Medicare policy, "...anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place." The requestor billed 7 units. The anesthesia record submitted for review did not document the amount billed (7 units). Therefore, reimbursement cannot be recommended.
- Date of service, December 4, 2003 the requestor billed CPT code 01905, defined as Anesthesia for myelography, discography, vertebroplasty. Per Medicare policy, "...anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place." The requestor billed 7 units. The anesthesia record submitted for review did not document the amount billed (7 units). Therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,232.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,232.60 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 7, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.